

**DELAWARE HEALTH CARE COMMISSION
SEPTEMBER 2, 2010
DELDOT ADMINISTRATION BUILDING
FARMINGTON/FELTON CONFERENCE ROOM
DOVER**

MINUTES

Commission Members Present: John C. Carney, Jr., Chairman; Theodore W. Becker, Jr.; Thomas J. Cook, Secretary of Finance; A. Richard Heffron; Rita Landgraf, Secretary, Delaware Health and Social Services; Janice E. Nevin, MD; Dennis Rochford; and Fred Townsend

Commission Members Absent: Lisa C. Barkley, MD; Vivian Rapposelli, Secretary, Services for Children, Youth and Their Families; and Karen Weldin Stewart, Insurance Commissioner

Staff Attending: Paula Roy, Executive Director; Marlyn Marvel, Community Relations Officer; and Linda G. Johnson, Administrative Specialist

CALL TO ORDER

The meeting was called to order at 9:00 a.m. by John Carney, Chairman.

MEETING MINUTES OF JUNE 3, 2010

Ted Becker made a motion to accept the June 3, 2010, meeting minutes. Tom Cook seconded the motion. After a voice vote the motion carried.

John Carney announced his resignation as Chairman of the Delaware Health Care Commission. Mr. Carney was pleased that his goal before completing his tenure as Chair was met when the DHIN legislation was passed at the last legislative session.

Mr. Carney introduced Bettina Riveros, who will assume the role of the Chairperson of the Delaware Health Care Commission. Ms. Riveros will provide a leadership role for Governor Markell's administration for health reform. She will focus on Affordable Care Act implementation.

RESEARCH AND POLICY DEVELOPMENT

Presentation: Affordable Care Act Implementation

Overview – Key Components of the Affordable Care Act and Timeline – Paula Roy

(This presentation is available on the Health Care Commission's website at <http://dhss.delaware.gov/dhcc/> under "Presentations")

Ms. Roy briefed the Commission on implementation activities to date and reviewed the basic components of the Affordable Care Act.

Action Item

Action

The Commission voted to accept the June 3, 2010, meeting minutes

John Carney announced his resignation as Chairman of the Delaware Health Care Commission.

Mr. Carney introduced Bettina Riveros, who will assume the role of the Chairperson of the Delaware Health Care Commission.

Insurance Reforms

There are a series of health insurance reforms and regulations which have been announced by Health and Human Services.

Health Care Coverage

By 2014 all United States citizens and legal residents will be required to have coverage.

Workforce

Because of expanded access to coverage, the Commission will need to be very serious about workforce development issues. There are provisions in the act which put resources into training, particularly in primary care and oral health.

There are provisions in the act for *Long Term Care; Medicaid and Medicare changes; Quality Improvement; System Reform and Prevention and Wellness*. Provisions were made for demonstration projects to experiment with new ways of delivering care, creating incentives for more primary care physicians and changing reimbursements.

Medicaid will expand to cover people up to 133 percent of the federal poverty level (FPL). Medicaid eligibility in Delaware is currently up to 100 percent of FPL.

Medicaid is going to shift from a program for low income people to avail themselves of coverage to the way people of certain income access coverage.

Ms. Roy stressed the importance of two documents distributed to members: *"Health Benefit Exchanges: An Implementation Timeline for State Policymakers"*, and *"State Policy Makers Priorities for Successful Implementation of Health Reform,"* from the National Academy for State Health Policy. These two publications will provide a foundation for understanding health care reform.

Discussion

John Carney said that, with the expansion of Medicaid to 133 percent of FPL, there is an overlap with the existing CHIP program. He asked if those people will automatically be enrolled in Medicaid.

Roseanne Mahaney, Director of the Division of Medicaid and Medical Assistance, responded that some CHIP enrollees will convert to Medicaid. The primary impact will be on childless adults; that is where the main expansion will be. At this time, adults are only covered at 100 percent of FPL.

Medicaid will expand to cover people up to 133 percent of the federal poverty level (FPL). Medicaid eligibility in Delaware is currently up to 100 percent of FPL.

Rita Landgraf said that the Long Term Care aspects of the Affordable Care Act are a big component. Long Term Care is the highest cost driver in the Medicaid program but is the smallest population. As people exhaust their resources and move out of Medicare and into Medicaid, the reform effort is to shift that and build a community based/home health care network of care. The Patient Protection and Affordable Care Act provides incentives to create better community based levels of care. It is less expensive to provide long term care in a community setting than in a facility based level of care. In Delaware, this will be critical when considering the State's demographics, particularly the increase in people age 60 and older.

Mr. Carney said he thought it would be more expensive to provide long term care in a community setting than in a facility based level of care and asked how those economics work.

Dr. Nevin responded that trips to the emergency room and hospital are reduced, and better disease management is provided. There have been a lot of studies done in this area. Johns Hopkins has a very robust home care program and has demonstrated that it is much more economical to provide services for the aging in their home than it is for them to go in and out of the hospital and nursing home.

Ms. Landgraf pointed out that nursing homes are moving to a more sub-acute level of care as opposed to a long term level of care. The Affordable Care Act will provide incentive funding to create a better, more robust community level of care. Workforce discussions should include home health care because it will be necessary to provide services to people in their home. Long term care insurance will be an important consideration.

Ms. Roy summarized the broad aspects of the Act: expanded coverage; insurance reforms; tax credits, premium subsidies and other tax changes; 'Exchanges' to purchase insurance; investment in workforce; investment in quality improvement and public health and prevention.

Implementation Activities to Date

Ms. Roy told Commissioners that several implementation activities has taken place over the summer and reviewed them for Commissioners.

Insurance Reforms

As previously mentioned, several insurance reforms in the ACA were announced this summer and will take effect beginning September 23, six months after the bill was signed into law.

Ms. Roy said that the Affordable Care Act has a provision that creates a temporary high risk pool for states with associated funding. The high risk pool was for people who had pre-existing conditions and had been uninsured for six months. The high risk pool ends January 2014, when the Exchange becomes active.

States had the option of operating their own high risk pool or defaulting to the federal government and letting the federal government run its high risk pool. Delaware decided to default to allow the federal government (Health and Human Services) to operate its temporary high risk pool, as did 17 other states.

Delaware's allotment was \$13 million through 2014. Most national experts agree the amount of money allocated to run the temporary high risk pools is insufficient.

Delaware does not have a high risk pool now and the amount of energy, time and resources to create and operate a high risk pool, with all of the Act's mandatory provisions coming, did not make sense to pursue.

Additional information is available at <http://www.healthcare.gov> and <http://www.delawareinsurance.gov> – click on 'Health Reform'.

Linda Nemes said the Department of Insurance (DOI) had to indicate to the Secretary of Health and Human Services whether it had sufficient authority to regulate federal mandates in the Affordable Care Act. On some mandates, DOI does not. As a result, a bill will be introduced in January 2011 to give the DOI that authority.

There are two areas under Delaware laws that DOI can regulate; one is the rescissions. In the last legislative session, Delaware passed a law that is more consumer friendly than what the federal government had passed. In Delaware, any company that fully insured will have to come to the Insurance Commissioner to ask for approval before a policy can be rescinded. That can provide an additional layer of protection.

Insurance reforms announced were:
No denial of coverage for children with pre-existing conditions

No lifetime limits on coverage. Plans will be prohibited from placing lifetime limits on coverage

Delaware decided to default to allow the federal government (Health and Human Services) to operate its temporary high risk pool, as did 17 other states.

Annual limits on coverage. Annual limits that plans can place on coverage will gradually be raised until 2013 when they will be eliminated entirely. Starting September 23, 2010 limits cannot be lower than \$750,000; September 23, 2011 - \$1.25 million, September 23, 2012 - \$2 million; January 1, 2013 – no limits

Required coverage for preventive services – Plans can no longer charge co-pays for access preventive services such as screenings, and immunizations. The provision applies to services with a rating of A or B of the United States Preventive Services Task Force.

Coverage for adult children – Plans must continue to cover adult children up to age 26 if they do not have other coverage, regardless of whether they are dependents or live with their parents.

Medical loss ratio- plans must devote 80 percent of expenditures to medical costs and 20% to administrative costs. The National Association of Insurance Commissioners are working on definitions of what expenditures constitute medical expenditures are expected to submit recommendations to the Secretary of Health & Human Services

Coverage for Early Retirees – Employers could apply to receive reimbursements for expenditures for early retirees between the ages of 55 and 65, when they qualify for Medicare. The purpose of the program is to encourage employers to maintain coverage for retirees. Employers are reimbursed 80% of claims costs between \$15,000 and \$90,000. Self funded plan could apply. In Delaware awards were announced for Astra-Zeneca, Christiana Care Health Systems, DuPont, New Castle County, Sentinel Transportation LLC and the State of Delaware.

Appeals for denial of coverage – New processes will be put in place to provide for internal and external appeals for consumers who have had coverage denied. Consumers can appeal decisions made by the health plans to an outside, independent decision-makers, no matter what state they live in or what type of health insurance they have.

Consumer Assistance – Grants are available to state insurance departments to help them improve consumer assistance activities. New activities can include helping consumers enroll in coverage, file complaints and tracking consumer complaints to better identify problems and strengthen enforcement of laws and regulations.

Premium Rate review grants – Grants of \$1 million were made available to all states to help them improve their process for reviewing premium rate increases. 45 states were awarded the grants.

Exchange

Starting 2014 individuals and employees of small businesses will purchase insurance through an Exchange. Grants were announced for all 50 states to apply for an exchange planning grant.

Tax Issues

Beginning tax year 2010 small businesses will be able to benefit from a tax credit of up to 35% of the employer's contribution to employee's insurance costs.

Medicare

Checks were mailed to Medicare enrollees who had reached the "donut hole" in coverage for prescription medication. Medicare Part D – the portion that pays for prescription drug costs has a gap in coverage between \$2,830 and \$6440, when coverage resume again. Checks in the amount of \$250 were mailed out over the summer, and on August 30, HHS announced that over 1 million checks had been issued.

Workforce

Workforce planning grants were announced, and Delaware submitted an application. The lead agency is the Workforce Investment Board, with close collaboration from the Health Care Commission and the Division of Public Health.

Access to Care

New access point grants were announced for federally qualified health centers, allowing them to expand access to care.

Information

The U.S. Department of Health and Human Services announced the new website *healthcare.gov*, a comprehensive resource to stay informed on the Affordable Care Act.

Presentation: Department of Insurance – Health Care Reform – Where are we now? – Linda Nemes

(This presentation is available on the Delaware Health Care Commission's website at <http://dhss.delaware.gov/dhcc/> under "Presentations")

Linda Nemes gave a presentation on the premium rate review grant that the Department of Insurance was awarded.

Premium Rate Review Grant

Most of the states do not have the authority to review rates and, until October 2009, neither did Delaware. Fortunately, the legislature passed a bill that gave the Insurance Commissioner the ability to approve or disapprove rates.

The federal government issued a grant for premium rate review to help the states. The Delaware DOI applied for the grant in July and was awarded \$1 million.

Purpose of Grant

Section 1003 of the Patients Protection Affordability Care Act (PPACA) provides for a program of grants to states to help them improve the rate review and reporting process.

How will the Department of Insurance use the grant?

One of the first priorities is transparency. One of the criticisms has been that the rate process takes place in a in a dark hole somewhere and no one knows how it is done or what is going on.

One of the methods DOI is going to use is to hold hearings on rate filings where the Commissioner has the opportunity to hear concerns from the consumer and the impact on the person purchasing the insurance and to have that in mind as we go through the process.

The Commissioner plans to hold meetings around the state between consumers, insurance carriers and the Department of Insurance.

The purpose is to put the spotlight on the ratemaking process; what goes into a rate; why it goes up; what a consumer does to affect his/her rate and what can be done to help hold that rate down.

It is not known how these plans are going to impact the DOI staff as far of the number of staff on board to analyze and process the rates. There are reporting requirements built into the law that each state will have to do with the rates so one position has been reclassified. DOI will be accessing the impact and will be asking for more federal money next year to increase the staff, if needed.

Another area is technology – DOI would like to have video conferencing but under the grant it was excluded so they could not add the extra equipment.

The Commissioner is putting video conferencing in the Dover office and wanted to expand it to the Wilmington office for training purposes so there would not have to be off site travel and to allow consumers to come into the Wilmington office and have more direct access.

DOI is looking at a mathematical software program that will permit the actuaries and the staff to get deeper into the insurance carrier's projections; to be sure those projections are accurate and soundly based so that decisions made with regard to permitting a premium increase will be based on solid information, independent of the carrier's projection.

SERFF Enhancement

SERFF is the software system of the National Association of Insurance Commissioners' (NAIC) used by DOI for processing of rates when they come through. It is all electronic. DOI does not accept paper. This enhancement will be to permit the State to prepare reports electronically for the federal government and to increase understanding of what is happening in the marketplace.

Equipment was included; including an upgrade in the screens for the use of the analysts for more efficiency.

Website Enhancements

The Department of Insurance would like to add a program to the web site to permit consumers to compare rates of carriers (similar to the auto compare currently in use) and provide a link to the carriers so a consumer can have more direct knowledge and make a better choice.

Presentation: The Patient Protection and Affordable Care Act – Roseanne Mahaney, Director, Division of Medicaid and Medical Assistance

(this presentation is available on the Statewide Calendar at <http://dhss.delaware.gov/dhcc/> under "Presentations")

Ms. Mahaney gave an overview of the Medicaid and CHIP provisions within the PPACA.

Mandatory Provisions

When the act was signed March 23, 2010, the first provision that went into effect was the *Maintenance of Effort* requirement. That means the current Medicaid and CHIP eligibility levels; application processes and methodology cannot become more restrictive until the State Health Benefit Exchange comes into account in 2014. When the State balances the budget in 2012, it cannot look at capping eligibility for Medicaid or CHIP.

There is a mandate as of July 1, 2011 that prohibits Medicaid payments related to health care acquired conditions. These are referred to as 'never events' - events that should never have occurred.

Effective January 1, 2013, Medicaid programs are required to increase reimbursement rates for primary care services to Medicare level.

Delaware Medicaid has traditionally paid its primary care physicians at 100 percent of Medicare. Delaware rolled those rates back a few years ago to 98 percent. When the requirement comes into effect, the federal government will pick up the difference and pay the 2 percent difference for 2 years.

There are a number of mandatory provisions that come into effect January 1, 2014, including expanding coverage under Medicaid to individuals with income up to 133% of the federal poverty level (FPL).

Chairman Carney said the practical impact is really childless adults in Delaware and asked how many of them there are.

Ms. Mahaney said there are about 27,000 childless adults enrolled in Medicaid in Delaware. Projections at this time indicate there will be an additional 18,000 by 2014 which the federal government will cover at 100 percent.

Effective January 1, 2014, income eligibility for Medicaid will be determined using modified adjusted gross income.

There will be a premium assistance program for employer-sponsored insurance.

States must streamline the Medicaid and CHIP enrollment process through the State Health Benefit Exchange.

Optional Provisions

There is a new state option for family planning services to males and females effective March 23, 2010.

There is a Medicaid Chronic Disease Incentive Payment program for individuals with at least two chronic conditions to designate a provider as a health home. This provision provides states with a 90 percent federal match to pay for some of their medical services. This becomes available January 1, 2011.

There is a demonstration project to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition, effective October 1, 2011 through December 31, 2015.

There is a Pediatric Accountability Care Organization Demonstration, beginning January 1, 2012 through December 31, 2016 that allows Medicaid pediatric providers to organize an affordable care organization.

All of these demonstrations are competitive grants that the State must apply for. There are requirements for reporting, data requirements and quality requirements under the grants. States may permit hospitals to make presumptive eligibility determinations for all Medicaid populations effective January 1, 2014.

Long Term Care Provisions

The "Money Follows the Person" program has been extended until 2016. The State applied for a "Money Follows the Person" grant to work with the Aging and Disability Resource Center to coordinate helping individuals transition from a nursing home into the community and was awarded \$400,000.00

There is a state option to offer more home and community based services. Currently most of the home and community based services are offered under a 1915C waiver that has strict reporting requirements and limitations. Delaware is looking at adding those services under the State plan under the PPACA and make them more accessible to individuals needing those services.

Available October 1, 2011, the *Community First* choice option would allow the State to add attendant care services to the State plan and access an additional 6 percent federal match for those services.

There is a state balancing incentive program, available October 1, 2011, that provides enhanced federal match for states that increase levels of community services for individuals needing those services.

Mandatory Program Integrity Provisions

In October 1, 2010, there is a mandatory use of National Correct Coding Standard in Medicaid claims processing system, which is enhanced editing and audits to ensure improper claims are not made to providers.

Effective January 1, 2011, there will be termination of a provider if terminated under Medicare or other state Medicaid program.

There will be expansion of the Recovery Audit Contractor (RAC) that goes into the hospital and looks for improper Medicaid payments and recover improper payments.

Billing agents, clearinghouse or other alternate payees will be required to register under Medicaid

There will be prohibition on payments to entities located outside of the United States.

Ted Becker requested that updates be provided at the October Commission meeting on Affordable Care Act developments as they occur.

Ms. Roy shared reputable web site resources for the Affordable Care Act. Those sites include:

Kaiser Family Foundation
www.kkf.org/healthreform

National Conference of State Legislatures
www.ncsl.org – click on 'Health Reform'

National Governor's Assn.
www.nga.org -click on 'Health Reform'

National Association of Insurance Commissioners
www.naic.org -click on 'special section: health reform'

Council of State Governments
www.csg.org – click on 'health reform resources'

UNINSURED ACTION PLAN

Update: Community Healthcare Access Program (CHAP)

Paula Roy provided an updated on the Community Healthcare Access Program (CHAP).

During FY10:

- Over 66,000 face-to-face encounters for direct services to CHAP people
- Over 7,000 referrals to medical specialty and private physicians through the VIP program.
- Over \$7.6 million in charity care was provided to CHAP patients
- Thirty three thousand eight hundred direct medical service visits
- Nearly 3,000 CHAP Enrollees were dually enrolled in hospital based charity programs
- Over 10,600 referrals to other state programs

Because of budget considerations, outreach has been eliminated from CHAP. At the June Commission meeting there was a question about how to proceed with Claymont Community Center because its activities included both outreach and primary care. Claymont Family Health Services is a primary care provider, and will continue to be a partner in CHAP as a health home providing primary care services.

Because of budget considerations, outreach has been eliminated from CHAP.

In consultation with CHAP partners, the Commission needs to think about what the CHAP becomes as 2014 approaches. An important lesson Ms. Roy learned from Massachusetts reforms, which are similar to many provisions of the Affordable Care Act, is that outreach is going to be key to successful implementation

Typically, the Commission has applied for CHAP funding through the Health Fund. Applications are due shortly and Ms. Roy asked if the Commission wants to pursue funding.

Action

Ted Becker made the motion to continue to apply for funding through the Health Fund for CHAP. Fred Townsend seconded the motion. Rita Landgraf abstained from voting because she is chair of the Health Fund Advisory Committee. After a voice vote the motion carried.

INFORMATION AND TECHNOLOGY

Update: Delaware Health Information Network (DHIN)
Gina Perez, Executive Director of the DHIN, updated the Commission on DHIN's status.

Ms. Perez thanked the Commission for the outstanding letter of support regarding the DHIN audit which provided a different perspective on the audit.

Senate Bill 231 was approved and signed by the Governor in July, effective January 1, 2011. It creates DHIN as a separate corporation outside of the State government but with ties to the State government for financing and reporting. The bill removes DHIN from the Health Care Commission and slightly changes composition of the Board of Directors. There are at-large positions on the Board and all appointments are made by the Governor, who can accept recommendations from the DHIN Board and associations which were able to make appointments in the current statute.

It is required there be an annual audit of the DHIN and reporting to the Governor and General Assembly on status and progress.

A budget of \$1.151 million was approved by the Bond Bill Committee; \$1 million to be used for new functions and features of the DHIN. The remaining \$151,000 is to provide state matching funds for the federal funding received under the Health Information Exchange (HIE) cooperative agreement, mostly to support the meaningful use requirement.

DHIN was released from Sunset Review with reporting requirements and the first report is due September 15, 2010.

Action

The Commission will continue to apply for funding through the Health Fund for CHAP.

Project update:

- 250 practices are enrolled in DHIN
- 30 percent of those practices are using DHIN as the sole Source of receiving results and reports
- 65 percent of providers in the State on the system
- Transcribed results have been implemented for Christiana Hospital and Bayhealth.

The long awaited “go live” with St. Francis Hospital will occur next week with lab results, radiology reports and admission face sheets. Phase two will be transcribed reports.

DHIN is in the process of signing a Memorandum of Agreement with the Department of Health and Social Services to support the federal grant and related activities to enhanced connectivity to the Division of Public Health, Medicaid and the Division of Substance Abuse and Mental Health.

The contractual DHIN staff will become employees of the DHIN.

Ms. Perez announced she is resigning her position as Executive Director of DHIN, effective June 30, 2011, but will continue on a contractual basis.

HEALTH PROFESSIONAL WORKFORCE DEVELOPMENT

Judy Chaconas announced a conference focused on “Recruitment and Retention” on September 21, 2010, at the Outlook at the Duncan Center, Dover.

Health reform will create new demands on the healthcare system and it will be essential to assure the workforce is adequate to meet those demands.

Dr. Karyl Rattay, Director of the Division of Public Health, will be opening the conference.

There will be a session on strengthening the workforce in time of change and testimonials on first-hand experience from clinicians who have gone through the State Loan Repayment Program, Conrad State 30, and the National Health Service Corps.

John Carney remembered former Commissioner Lois Studte advocated for a research and data center on workforce needs. He asked if anyone is looking at the actual needs we have in light of the changes in the number of insured?

Ms. Roy said that is the purpose of the Workforce Planning Grant.

Update: State Loan Repayment Program (SLRP)

Ted Becker provided funding updates of the State Loan Repayment Program.

The Loan Repayment Program has the following funds available for distribution:

- \$150,000 available in State DIMER funds through June 30, 2011
- \$92,214 available in State DIDER funds through June 30, 2011
- \$100,000 available in federal matching funds through August 30, 2011
- \$100,000 available in ARRA federal matching funds through September 29, 2011

Remaining in current FY 2010 federal funds

- \$52,000 available in ARRA federal matching funds through September 29, 2010
- \$143,000 available in federal matching funds through August 30, 2010

The State will need to match federal carry over funds dollar for dollar. In FY 2011, the program has been awarded a total of \$200,000 in new federal funds and has a total of \$242,214 in state funds. If the State had more money to match the federal funds, we would be able to use those funds better for DIMER and DIDER.

Action

Ted Becker made a motion to maximize opportunities to use federal grant funds for loan repayment by requesting additional state funds and submitting a request to carry over federal funds from FY2010. Dr. Nevin seconded the motion. Rita Landgraf and Thomas Cook abstained from voting. After a voice vote the motion carried.

Tom Cook pointed out that should additional state monies be allocated for the State Loan Repayment Program, the funds would have to come from the existing budget by reducing funding for other programs.

Sickle Cell Disease Project

At the June Commission meeting, Commissioners approved developing a pilot program on Sickle Cell Disease Management. Ms. Roy advised members a contract has been executed.

Action

The Commission approved maximizing opportunities to use federal grant funds for loan repayment by requesting additional state funds and submitting a request to carry over federal funds from FY2010.

Commissioners approved developing a pilot Sickle Cell Disease Management program and a contract has been executed.

PUBLIC COMMENT

Dr. JoAnn Fields asked Linda Nemes for clarification on part of her presentation. Did she say we do *not* have a rigorous premium review process and we *will*? Is there a timeline when a rigorous, transparent process will be in place? With regard to Medicaid, a recovery audit and user fees, will there be a penalty system in place for insurance companies that do not have accurate data and ask for too much?

Ms. Nemes answered that the Department of Insurance (DOI) has always looked at rates and has actuaries who verify that the appropriate calculations are made by the insurance carriers. Previously all DOI could do was say the rates were excessive. Now there is a formal ability to say the carrier is definitely out of line with its rates and DOI is not going to approve it.

The SERFF program will enable DOI to get deeper into the rate calculations and look at what the Department actuaries calculate and compare that to the insurance carrier's actuaries and reconcile those calculations if there is a diversion between them.

This is a one year grant cycle and DOI plans to have everything implemented and in place by September 30, 2011.

Carriers who do not meet the criteria will not see their increases take effect and will know they have to provide better information. If a carrier participates in activities that are contrary to Delaware law, DOI always has the ability to take those carriers to hearings and conduct exams. If violations are found or the carrier is being deceptive, the DOI can take action.

Brian Posey, of AARP, said that from the consumer's viewpoint, statistics in Delaware and nationwide consistently show only about 4 to 5 percent of individuals would choose nursing home or facility care for themselves or family members. Overwhelmingly, the rest say they would rather remain independent in their home instead.

In Delaware, the average Medicaid long term care facility case payment is about \$81,000 per year. Facility case payment through the waiver program in Delaware, which helps keep people out of nursing homes, is around \$16,000 a year. Eligibility for Medicaid payments for nursing home care in Delaware is being limited to the ability to do only *one* of the following: toileting, feeding, or preparing meals, etc.

The way the Medicaid system was set up has a bias towards all-in-one care, which is to go into a nursing facility. The “Money Follows the Person” program, which the federal government has really encouraged states to afford, has addressed that imbalance. That is, to *not* have nursing home care as the default or easy way to go. It is to go through the navigation process of finding a way to keep the person in their home.

Rita Landgraf added that is not to say that at some point in someone’s lifetime they will need that higher level of care that only a facility will be able to provide but it is to be able to create that community based network. We are starting to transition and build that workforce that is based in the community to better support individuals that do not need the 24 hour facility care.

Ms. Landgraf said the Center for Medicaid and Medicare Services and the United States Department of Justice have been very critical of Delaware for not moving more aggressively in that direction. They say, by looking at just the state facilities, a state of Delaware’s population size having five facility based care centers is appalling.

Lolita Lopez thanked John Carney for all the work he has done on the Commission over the years and said that his tenacity for getting to the bottom of issues has served us all very well. She also thanked him or all of the support for the Health Centers.

NEXT MEETING

The next meeting of the Delaware Health Care Commission will be held on Thursday, October 7, at 9:00 a.m. at the DeIDOT Administration Building in the Farmington/Felton Conference Room, 800 Bay Road, Dover.

ADJOURN

The meeting adjourned at 11:45 a.m.

NEXT MEETING

The next meeting of the Delaware Health Care Commission will be held on Thursday, October 7, at 9:00 a.m. at the DeIDOT Administration Building in the Farmington/Felton Conference Room, 800 Bay Road, Dover.

GUESTS

Judith Chaconas	DHSS/Division of Public Health/Bureau of Health Planning Management
Jeanne Chiquoine	American Cancer Society
J'Aime Conrad	Pfizer Co.
Barbara DeBastiani	Wheeler and Associates
Dr. JoAnn Fields	Family Practice Physician
Joann Hasse	League of Women Voters
Rebecca Kidner	R.B. Kidner, PA
Lolita Lopez	Westside Family Healthcare
Anna McGhee	Health Resources Services Administration
Linda Nemes	Department of Insurance
Sheila Nutter	Hewlett Packard
Gina Perez	Advances in Management
Brian Posey	AARP
Karyl Rattay	Division of Public Health
Rosa Rivera	Henrietta Johnson Medical Center
Lillian Ronneberg	Hewlett Packard
Christine Schultz	Parkowski, Guerke and Swayze
Jose Tieso	Hewlett Packard
Wayne Smith	Delaware Healthcare Association
Betsy Wheeler	Wheeler and Associates